DEPARTMENT OF MENTAL HEALTH/MENTAL RETARDATION SERVICES
DISCLOSURE TRACKING LOG

Division_____

Consumer Name: _____
MEDICAL RECORD NUMBER: _____00-48-90_____

Date Received	Name of Requestor*	Address* if known	Authorization or Written Request	Purpose*	PHI Disclosed *	Date Disclosed *	Disclosed by	Amount Billed	Amt. Received	Date Received
5/14/03	John Doe, Esq.	44 Brown Avenue Claremont, NH 03743	Authorization	See Auth form	ER Record 4/20/23	5/24/03	B Tiller	$7.00	$7.00	5/14/03

* Fields required by HIPAA privacy standards. Note: fields can be incorporated into a computerized tracking system

REQUESTS FOR ACCOUNTING OF DISCLOSURES:

Requested by (Consumer/Legal Rep)	Date Requested	Date Range Requested	Staff Completing Request	Date Provided
.Mary Smart	8/23/03	4/14/03 – 8/23/03	B Tiller	9/24/03

(Use this section to document accounting requests when a copy of this disclosure log is provided to the individual)

Key:
Date received: the date request is received to disclose or release information when applicable
Name of requester: name of entity or person requesting information to be disclosed or released
Address: if known, the address of the entity or person requesting information to be disclosed or released
Authorization or written request: identify if there is a written request or authorization. If not, indicate how request was received (i.e.verbal)
Purpose: brief description of the purpose of the disclosure to reasonably inform the individual of the basis of the disclosure. If documented on authorization or written request, state "see authorization/written request"
PHI disclosed: brief description of the information disclosed/released
Date disclosed: date the information was released or disclosed
Sent by: staff member processing the request and disclosing the information
Amount billed: if applicable, the copy fee charged for records released
Amount received: copy fee received
Date received: date the fee was received

ATTACHMENT I

DISCLOSURE TRACKING LOG

CONSUMER NAME: _____
MEDICAL RECORD NUMBER: _____

Date Received	Name of Requestor*	Address* if known	Authorization or Written Request	Purpose*	PHI Disclosed *	Date Disclosed *	Disclosed by	Amount Billed	Amt. Received	Date Received

* Fields required by HIPAA privacy standards. Note: fields can be incorporated into a computerized tracking system

REQUESTS FOR ACCOUNTING OF DISCLOSURES:

Requested by (Patient/Legal Rep)	Date Requested	Date Range Requested	Staff Completing Request	Date Provided

(Use this section to document accounting requests when a copy of this disclosure log is provided to the individual)

Filename:	Disclosure Tracking Log--NHV.htm--DEPT.doc
Directory:	D:\Documents and Settings\bomayo\Desktop
Template:	D:\Documents and Settings\bomayo\Application Data\Microsoft\Templates\Normal.dot
Title:	DISCLOSURE TRACKING LOG
Subject:	
Author:	Valued Gateway Client
Keywords:	
Comments:	
Creation Date:	6/7/2002 8:33 AM
Change Number:	2
Last Saved On:	6/7/2002 8:33 AM
Last Saved By:	dschroeder
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